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### Legislature's Attempt to Meet Medical Malpractice Crisis

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These long overdue recognitions of standing afford the public greater participation in the governmental process. Although article 7-A of the State Finance Law provides for guidelines absent in *Boryszewski*, further legislative and judicial clarification and explanation of both the article and the case law is needed.<sup>279</sup> This articulation must not be delayed, for uncertainty as to threshold requirements such as standing overly encumber the decision to initiate an otherwise meritorious action. The practitioner should be aware of the inconsistencies between article 7-A and *Boryszewski* as well as the issues posed by a close examination of article 7-A itself and frame his standing argument accordingly.

*Legislature's attempt to meet medical malpractice crisis.*

The rising cost of medical malpractice insurance<sup>280</sup> has caused consternation within the medical profession. Pressured by the doubling of premium costs and the possibility that many insurance companies might curtail or abolish protection, doctors across the country have protested by staging or threatening strikes.<sup>281</sup> In New York, the threat of a walkout by the medical profession induced the legislature<sup>282</sup> to extensively revise the law of medical malpractice.<sup>283</sup> The major changes became effective July 1, 1975 and apply to acts of malpractice occurring on or after that date.<sup>284</sup>

One of the enactments provided for the creation of a medical malpractice insurance association.<sup>285</sup> Composed of "all insurers au-

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<sup>279</sup> Clarification should be based on an evaluation of the various public policy considerations underlying the different treatment accorded actions under the State Finance Law, the General Municipal Law, and *Boryszewski*. It is submitted that a consistent overall approach to citizen-taxpayer actions would be preferable.

<sup>280</sup> Insurance costs have risen astronomically. As of 1975, the rates averaged 16 times those charged in 1966, with further increases predicted in the near future. N.Y. Times, June 1, 1975, § 1 (News), at 47, col. 5.

It is interesting to note that as of 1975 more than 7000 of the 12,000 physicians practicing in New York City and Nassau County were paying premiums of \$2067 or less. *Id.*, June 1, 1975, § 1 (News), at 46, col. 3. When compared to other insurance expenses, such as automobile coverage, this amount does not seem excessive. While it is true that some physicians in high-risk specialties pay top premiums of up to \$14,329, *id.*, these physicians usually charge higher fees for their services.

<sup>281</sup> *E.g.*, *id.*, May 2, 1975, at 1, col. 1; *id.* May 21, 1975, at 30, col. 6 (doctors' strike on West Coast).

<sup>282</sup> *Id.*, May 16, 1975, at 1, col. 3.

<sup>283</sup> Ch. 109, §§ 1-37, [1975] N.Y. Laws 134 (McKinney) (codified in scattered sections of N.Y. BUS. CORP. LAW; CPLR; N.Y. EDUC. LAW; N.Y. INS. LAW; N.Y. JUDICIARY LAW; N.Y. PUB. HEALTH LAW; N.Y. WORKMEN'S COMP. LAW). While there is no general definition of medical malpractice applicable to the whole package of malpractice legislation, the term is defined in the enactment's amendment to the Insurance Law to include liability for death or injury caused by a "licensed physician or hospital." N.Y. INS. LAW § 681(2) (McKinney Supp. 1975). Perhaps that definition will be held to apply to other statutes in the new legislation as well. See 7B MCKINNEY'S CPLR 3403, commentary at 13 (Supp. 1975).

<sup>284</sup> Ch. 109, § 37, [1975] N.Y. Laws 157 (McKinney).

<sup>285</sup> N.Y. INS. LAW §§ 681-95 (McKinney Supp. 1975).

thorized to write . . . personal injury liability insurance,"<sup>286</sup> the association has the power to issue insurance policies subject to the approval of the Superintendent of Insurance.<sup>287</sup> The purpose of the association is to alleviate some of the difficulties doctors face in trying to obtain medical malpractice insurance.<sup>288</sup> It fulfills this purpose at least to the extent of assuring doctors basic protection; it is anticipated, however, that the burden of the high cost of the policies, so irksome to the profession, will not be alleviated.<sup>289</sup> Thus, the creation of the association may well prove to be a surface cosmetic with little permanent value. Many doctors, dissatisfied with the enactment, reacted by forming their own insurance carrier.<sup>290</sup>

Even if the insurance association does not provide significant monetary relief from the high cost of coverage, sweeping changes

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<sup>286</sup> *Id.* § 682(1). Specifically excluded from this definition are assessment cooperative fire insurance companies. *Id.*

<sup>287</sup> Policy coverage for physicians is limited to \$1 million for each injured party and \$3 million for all claimants under any one policy in a year. *Id.* § 682(5)(a)(1). Hospitals may obtain excess coverage provided "the coverage in excess of such limits shall be fully reinsured for the term of the policy." *Id.* § 682(5)(a)(2). Policy forms must be filed with and approved by the Superintendent of Insurance. *Id.* § 684(1).

The rates for each doctor are to be calculated "on an actuarially sound basis, . . . to be self-supporting, . . . based upon reasonable standards, and may give consideration to such factors as the experience of the insured, geographical area and specialties of practice." *Id.* § 684(2). Another factor which will undoubtedly figure in any calculation of rates is the proficiency of the doctor as measured in terms of claims made against him.

If the contract contains a deductible clause, the doctor is permitted to purchase an option whereby the association is not allowed to settle any claim under the policy without his consent. *Id.* § 684(4). This is an attempt by the legislature to make the choice of a deductible clause more attractive to doctors. Probably because the physician's professional reputation is at stake, it has been common practice not to settle malpractice claims without consent. See, e.g., MEDICAL LIABILITY MUTUAL INSURANCE COMPANY, PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY POLICY (home office: Lake Success, New York). Most liability insurance policies, however, leave the question of settlements to the sole discretion of the insurer. See Keeton, *Liability Insurance and Responsibility for Settlement*, 67 HARV. L. REV. 1136, 1138 (1954). Difficulties arise where the suit is brought for more than the insured's coverage. In such a situation, if the insurance company refuses an equitable settlement, the insured may be liable for the excess. The insurer may also settle weak claims in order to avoid going to trial. The option will give the insured a decisive vote in settlement decisions.

To provide the association with a cash reserve, each insured must pay into an "annual stabilization reserve fund" an amount "equal to twenty percent of the annual premium charge." N.Y. INS. LAW § 688 (McKinney Supp. 1975). Once the reserve reaches \$50 million, the annual surcharge ceases; upon dissolution of the association, any excess funds will be distributed to the participants. *Id.*

<sup>288</sup> See Governor's Memorandum, May 21, 1975, as appearing in [1975] N.Y. Laws 1739 (McKinney), on approving ch. 109, §§ 1-37, [1975] N.Y. Laws 134 (McKinney).

<sup>289</sup> Senator John R. Dunne (R. Garden City) indicated that even with this new legislation, doctors could still expect a premium increase of between 75% and 80%. N.Y. Times, May 16, 1975, at 11, col. 1.

<sup>290</sup> *Id.*, May 29, 1975, at 22, col. 4. A recent revision in the new malpractice legislation permitting self-insurance provides doctors with another way to take matters into their own hands and possibly save money. N.Y. WORKMEN'S COMP. LAW § 101 (McKinney Supp. 1975). Doctors can now consider self-insuring themselves to a certain minimum level and purchasing insurance protection for claims exceeding that amount.

in tort law governing medical malpractice portend a decrease in costs by reducing the number of claims filed. Major changes in this area were effected with respect to the statute of limitations by the legislature's addition of section 214-a to the CPLR. Under the CPA malpractice was governed by a 2-year limitation period.<sup>291</sup> With the adoption of the CPLR, the statute of limitations for malpractice was increased to 3 years, the same as that for other negligence actions.<sup>292</sup> Now, in an attempt to reduce the number of claims which can be brought, the limitation period has been shortened to 2½ years from the time the cause of action accrued.<sup>293</sup> While a statute of limitations has the beneficial purpose of preventing stale claims,<sup>294</sup> this enactment, passed solely to cut off otherwise viable causes of action, seems rather one-sided. It must be pointed out, however, that the new statute of limitations is still not as favorable to physicians as was the CPA.

A concomitant consideration also dealt with in CPLR 214-a is the time of accrual. The general rule has been that the cause of action accrues at the time the act of malpractice is committed.<sup>295</sup> Unfortunately, the patient is often unaware of the injury for some time after the act of malpractice. To soften the often harsh effects of this rule, the judiciary developed an exception for continuous treatment.<sup>296</sup> When medical care extends over a period of time, the

<sup>291</sup> CPA 50(1).

<sup>292</sup> Ch. 308, § 214(6), [1962] N.Y. Laws 1310.

<sup>293</sup> CPLR 214-a.

<sup>294</sup> One student author has noted:

The primary consideration underlying such legislation is undoubtedly one of fairness to the defendant. There comes a time when he ought to be secure in his reasonable expectation that the slate has been wiped clean of ancient obligations, and he ought not to be called on to resist a claim when "evidence has been lost, memories have faded, and witnesses have disappeared."

Note, *Developments in the Law — Statutes of Limitations*, 63 HARV. L. REV. 1177, 1185 (1950) (footnote omitted), quoting *Order of R.R. Telegraphers v. Railway Express Agency*, 321 U.S. 342, 349 (1944). A similar point of view was expressed by the Supreme Court in the early case of *Riddlesbarger v. Hartford Ins. Co.*, 74 U.S. (7 Wall.) 386, 390 (1868).

<sup>295</sup> *Conklin v. Draper*, 229 App. Div. 227, 241 N.Y.S. 529 (1st Dep't), *aff'd mem.*, 254 N.Y. 620, 173 N.E. 892 (1930); Lillich, *The Malpractice Statute of Limitations in New York and Other Jurisdictions*, 47 CORNELL L.Q. 339, 340 (1962).

<sup>296</sup> *Borgia v. City of New York*, 12 N.Y.2d 151, 187 N.E.2d 777, 237 N.Y.S.2d 319 (1962). The continuous treatment rule was first applied in New York in *Sly v. Van Lengen*, 120 Misc. 420, 422, 198 N.Y.S. 608, 610 (Sup. Ct. Onondaga County 1923) ("plaintiff's cause of action accrued as much by reason of the alleged continuous breach of duty on the part of the defendant . . . as it did because of the alleged negligent act . . .").

The continuous treatment doctrine originated in a decision of the Supreme Court of Ohio, *Gillette v. Tucker*, 67 Ohio St. 106, 65 N.E. 865 (1902). The *Gillette* court set forth considerations for the theory that are still applicable today:

Indeed, it would be inconsistent to say that the plaintiff might sue for her injuries while the surgeon was still in charge of the case, and advising and assuring her that proper patience would witness a complete recovery. It would be trifling with the law and the courts to exact compliance with such a rule, in order to have a standing in court for the vindication of her rights. It would impose upon her an improper

cause of action is deemed not to accrue until the date of the last treatment.<sup>297</sup> As enunciated by the Court of Appeals in *Borgia v. City of New York*,<sup>298</sup> the continuous treatment doctrine applies in the case of "treatment for the same or related illnesses or injuries, continuing after the alleged acts of malpractice, not mere continuity of a general physician-patient relationship."<sup>299</sup> There is some question as to whether this doctrine has been limited by the new legislation<sup>300</sup> since CPLR 214-a restricts continuous treatment to "the same illness, injury or condition which gave rise to the said act [of malpractice]." In addition, the new statute excludes from continuous treatment "examinations undertaken at the request of the patient for the sole purpose of ascertaining the state of the patient's condition." Apparently, this was intended to forestall attempts to unilaterally extend the statute of limitations where continued treatment was not in fact needed. It should not preclude the extension of the limitation period by any subsequent visits for the treatment of complications arising from the malpractice.

Section 214-a of the CPLR also codifies the foreign object discovery rule propounded by the Court of Appeals in *Flanagan v. Mount Eden General Hospital*.<sup>301</sup> Prior to this decision, application of the general rule<sup>302</sup> in cases where a foreign object had been negligently left in the patient's body often resulted in a running of the statute of limitations before the patient could have known he had a cause of action. Realizing the inequity of such a result, the *Flanagan* Court ruled that "where a foreign object has negligently been left in the patient's body, the Statute of Limitations will not begin to run until the patient could have reasonably discovered the malpractice."<sup>303</sup> The *Flanagan* rule was subsequently interpreted as

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burden to hold that, in order to prevent the statute from running against her right of action, she must sue while she was following the advice of the surgeon, and upon which she all the time relied.

*Id.* at 119, 65 N.E. at 871.

<sup>297</sup> *Borgia v. City of New York*, 12 N.Y.2d 151, 155, 187 N.E.2d 777, 778, 237 N.Y.S.2d 319, 321 (1962); *Richmond v. Capers*, 30 App. Div. 2d 976, 294 N.Y.S.2d 651 (2d Dep't 1968) (mem.).

<sup>298</sup> 12 N.Y.2d 151, 187 N.E.2d 777, 237 N.Y.S.2d 319 (1962).

<sup>299</sup> *Id.* at 157, 187 N.E.2d at 779, 237 N.Y.S.2d at 322 (emphasis added). No further acts of malpractice need occur during the course of the continued treatment. See O'Laughlin v. Salamanca Hosp. Dist. Auth., 36 App. Div. 2d 51, 319 N.Y.S.2d 128 (4th Dep't 1971), discussed in *The Quarterly Survey*, 46 ST. JOHN'S L. REV. 147, 150 (1971).

<sup>300</sup> But see Kramer, *Medical Malpractice*, 174 N.Y.L.J. 51, Sept. 11, 1975, at 1, col. 1, wherein the author contends that the new law "restates" the *Borgia* rule. *Id.* at 5, col. 1.

<sup>301</sup> 24 N.Y.2d 427, 248 N.E.2d 871, 301 N.Y.S.2d 23 (1969) (surgical clamps left in plaintiff's body not discovered until 8 years later when patient experienced severe abdominal pain).

<sup>302</sup> See note 295 and accompanying text *supra*.

<sup>303</sup> 24 N.Y.2d at 431, 248 N.E.2d at 873, 301 N.Y.S.2d at 27. The Court remarked that any other result would be "an undue strain upon common sense, reality, logic and simple

affording a plaintiff the right to bring his action within either 3 years from the commission of the act of malpractice or 2 years from the date of actual or imputed discovery.<sup>304</sup> The new legislation changes the latter time period to 1 year from either the date of discovery or "the date of discovery of facts which would reasonably lead to such discovery, whichever is earlier."<sup>305</sup>

In several respects, the new legislation reverses the progressive trend taken by New York lower courts since *Flanagan*. In *Dobbins v. Clifford*,<sup>306</sup> the Appellate Division, Fourth Department, expanded the *Flanagan* rule to a case which did not involve a foreign object. The plaintiff in *Dobbins* had sustained damage to his pancreas during an operation. The damage was not discovered until 4 years later. The court, applying the *Flanagan* approach, found that

an act of malpractice [had been] committed internally so that discovery [was] difficult; real evidence of the malpractice in the form of the hospital record is available . . . ; professional diagnostic judgment is not involved, and there is no danger of false claims.<sup>307</sup>

The legislature made no reference to the *Dobbins* situation although CPLR 214-a specifically codifies both the *Borgia* continuous treatment and the *Flanagan* foreign object exceptions. This would appear to militate against judicial application of the *Dobbins* exception in the future.

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justice . . . ." *Id.* at 431, 248 N.E.2d at 873, 301 N.Y.S.2d at 26, quoting *Morgan v. Grace Hosp., Inc.*, 149 W. Va. 783, 792, 144 S.E.2d 156, 161 (1965).

<sup>304</sup> Subsequent to the *Flanagan* decision it was suggested that the foreign object discovery rule should be subject to CPLR 203(f). 7B McKINNEY'S CPLR 214, commentary at 435. CPLR 203(f) provides in pertinent part that

where the time within which an action must be commenced is computed from the time when facts were discovered or from the time when facts could with reasonable diligence have been discovered, . . . the action must be commenced within two years after such actual or imputed discovery or within the period otherwise provided, computed from the time the cause of action accrued, whichever is longer.

Indeed, in *Slagen v. Marwill*, 78 Misc. 2d 275, 356 N.Y.S.2d 511 (Sup. Ct. Saratoga County 1974), the court held that a foreign object medical malpractice action must be commenced within the limitation set forth in CPLR 203(f). Since the plaintiff in *Slagen* had commenced the action more than 3 years after the alleged malpractice and more than 2 years after its discovery, the court dismissed the complaint as untimely.

<sup>305</sup> CPLR 214-a. There is some disagreement as to whether the discovery rule preempts the basic limitation period of 2½ years. While it seems reasonable to give the plaintiff at least the statutory period to bring his action, with the discovery rule serving only to extend the statutory period if needed, Dean Joseph M. McLaughlin contends that

a plaintiff can never get the benefit of the two-and-one-half year statute of limitations in a foreign objects case. In other words, if the patient discovers a foreign object in his body within three months after the surgeon negligently leaves it there, the patient appears to be bound by the one-year statute of limitations.

7B McKINNEY'S CPLR 214-a, commentary at 49 (Supp. 1975) (emphasis in original).

<sup>306</sup> 39 App. Div. 2d 1, 330 N.Y.S.2d 743 (4th Dep't 1972), discussed in *The Quarterly Survey*, 47 ST. JOHN'S L. REV. 148, 153 (1972).

<sup>307</sup> 39 App. Div. 2d at 4, 330 N.Y.S.2d at 746-47.

The new malpractice legislation specifically prohibits the extension given the *Flanagan* rule by the Appellate Division, Second Department, in *Murphy v. St. Charles Hospital*.<sup>308</sup> The *Murphy* court applied the foreign object discovery rule to a malpractice action involving a patient injured when a prosthetic device broke.<sup>309</sup> By excluding prosthetic devices from the meaning of the term "foreign object," CPLR 214-a precludes reliance on the foreign object discovery rule in this situation.<sup>310</sup> This appears particularly unfair to the patient, since he may be effectively precluded from bringing a cause of action for malpractice.<sup>311</sup>

CPLR 208, which tolls the statute of limitations for plaintiffs under the disability of infancy or insanity, has also been amended. In general, CPLR 208 provides that if the time limit for commencing the action is 3 years or more, the plaintiff has up to 3 years from the date the disability ceases to institute the action.<sup>312</sup> Mal-

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<sup>308</sup> 35 App. Div. 2d 64, 312 N.Y.S.2d 978 (2d Dep't 1970), discussed in *The Quarterly Survey*, 45 ST. JOHN'S L. REV. 500, 507 (1971).

<sup>309</sup> 35 App. Div. 2d at 67, 312 N.Y.S.2d at 980. The court noted an additional reason for allowing the action:

[T]he plaintiffs' cause of action could not have accrued before the prosthesis broke because a necessary element of the cause of action — injury — had not yet occurred. . . . [I]t is only where the negligent act creates damage or injury that a cause of action comes into being.

*Id.*

<sup>310</sup> See 7B MCKINNEY'S CPLR 214-a, commentary at 49 (Supp. 1975). CPLR 214-a specifically states: "For the purpose of this section the term 'foreign object' shall not include a chemical compound, fixation device or prosthetic aid or device."

<sup>311</sup> If the problem is caused by a defective device, as opposed to faulty installation, the plaintiff would probably have available a cause of action in breach of warranty or strict products liability. As to negligently installed devices, however, the plaintiff may be barred by the running of the statute of limitations before he even becomes aware of his cause of action. Before the running of the statute the plaintiff may have only slight difficulties which are not yet significant enough to cause him to seek medical attention and/or which he does not realize are related to the negligent installation. Moreover, the patient may also be unable to rely on the continuous treatment doctrine. Treatments sought by the patient after the installation of the device could be considered examinations "undertaken at the request of the patient for the sole purpose of ascertaining the state of the patient's condition." CPLR 214-a. The patient can only hope that the courts strictly construe "sole purpose" so as to permit the application of the continuous treatment doctrine where the requested examination could relate to prior improper treatment. Dean McLaughlin's comments are appropriate in this regard:

Granted that the purpose of a statute of limitations is to protect the defendant from stale claims, one may question whether this should ever be achieved at the expense of a plaintiff who did not and could not have known of the defendant's malpractice. . . . It is grim logic indeed which concludes that a patient may commence an action even before he knows that he has an action to commence.

7B MCKINNEY'S CPLR 214, commentary at 434 (1972).

<sup>312</sup> CPLR 208 provides in pertinent part:

If . . . the time otherwise limited for commencing the action is three years or more and expires no later than three years after the disability ceases, or the person under the disability dies, the time within which the action must be commenced shall be extended to three years after the disability ceases or the person under the disability dies, whichever event first occurs . . . .

practice actions were formerly included in this category.<sup>313</sup> Where the time within which the action must be commenced is less than 3 years, the limitation period is only extended by the duration of the disability.<sup>314</sup> As a result of the reduction in the statute of limitations from 3 to 2½ years, malpractice now falls within the latter provision.<sup>315</sup> If the disability is insanity, it has long been the rule that the statute is not to be tolled for more than 10 years after the cause of action accrues.<sup>316</sup> As a result of the 1975 amendment to CPLR 208, that limitation now also applies to infants injured because of medical malpractice.<sup>317</sup>

There are two possible approaches to the subject of statutes of limitation. The first can be traced back to the civil law doctrine that "limitations statutes should be viewed as extinguishing the claim and destroying the right itself."<sup>318</sup> The more prevalent view in this country, however, is that statutes of limitations do nothing more than "cut off resort to the courts for enforcement of a claim."<sup>319</sup> As a result, the United States Supreme Court has indicated that these statutes are within the legislative sphere and do not infringe upon a natural or fundamental right.<sup>320</sup> The practical effect, however, of limiting the statute of limitations to 10 years in cases of infants' medical malpractice claims is to deny those infants the right to have their claims resolved if neither the infants' parents or guardian institute an action on their behalf. Conceivably, there will be children injured through the negligence of a doctor shortly after birth, who will therefore be only 10 years old at the time the statute of limitations has run.<sup>321</sup> A child may not bring an action until he is 18;<sup>322</sup> yet, he is now required to institute a malpractice action before he is 10. While it is true that parents and guardians will be able to bring the action within the statutory period,<sup>323</sup> the child should not be precluded from recovery by the inaction of others. This is the very rationale behind tolling the limitation periods when infants are involved.<sup>324</sup>

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<sup>313</sup> See note 292 and accompanying text *supra*.

<sup>314</sup> CPLR 208.

<sup>315</sup> See note 293 and accompanying text *supra*.

<sup>316</sup> CPLR 208.

<sup>317</sup> *Id.*

<sup>318</sup> *Chase Sec. Corp. v. Donaldson*, 325 U.S. 304, 313 (1945).

<sup>319</sup> *Id.* (footnote omitted).

<sup>320</sup> *Id.* at 314.

<sup>321</sup> *Kramer, Medical Malpractice*, 174 N.Y.L.J. 51, Sept. 11, 1975, at 5, col. 1.

<sup>322</sup> See CPLR 105(j), 1201.

<sup>323</sup> *Id.* 1201.

<sup>324</sup> See SECOND REP. 58.



Another area in the law of medical malpractice which was substantially revised by the new legislation is the doctrine of informed consent.<sup>325</sup> A physician may be held liable under this doctrine for his failure to adequately inform the patient of risks incident to the particular treatment, even though the treatment itself was proper.<sup>326</sup> The question thus arises whether the scope of disclosure of known dangers was reasonable. The traditional approach has been that the applicable standard of care is that of the medical community, which the plaintiff must prove by use of expert testimony.<sup>327</sup> More recently, courts have dispensed with the need of expert testimony by adopting the negligence standard of reasonable care,<sup>328</sup> thus alleviating the plaintiff's burden. The new

<sup>325</sup> The doctrine of informed consent has as its basis the tort principle that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914). See Smith, *Antecedent Grounds of Liability in the Practice of Surgery*, 14 ROCKY MT. L. REV. 233, 236 (1942). As a result, the failure of the physician to obtain permission for the treatment is the tort of battery. Note, *Consent as a Prerequisite to a Surgical Operation*, 14 U. CIN. L. REV. 161, 162 (1940). The distinction between the tort action where the patient did not consent and the negligence action where there was a lack of informed consent because the patient was not adequately apprised of the risks involved is discussed in 7B MCKINNEY'S CPLR 214, commentary at 39 (Supp. 1975). In one area, however, the physician is protected from a failure to obtain consent, i.e., where the doctor aids the public in an emergency situation. N.Y. EDUC. LAW § 5527(2) (McKinney 1972). The aid must be without an expectation of monetary compensation and must be rendered at the scene of the accident. The physician in such a situation is only liable for his gross negligence. *Id.*

<sup>326</sup> See, e.g., *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (4th Dep't 1973); *Fiorentino v. Wenger*, 26 App. Div. 2d 693, 694, 272 N.Y.S.2d 557, 559 (2d Dep't 1966), *rev'd on other grounds*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

The plaintiff must show that he received his injury while undergoing treatment that he ordinarily would not have consented to were all the material risks known. See Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U.L. REV. 628, 646-48 (1969). Where the plaintiff is unable to consent, i.e., in a coma, and it is necessary to operate before consent can be obtained, there is no requirement to disclose. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 130, 105 N.E. 92, 93 (1914).

<sup>327</sup> *Petterson v. Lynch*, 59 Misc. 2d 469, 299 N.Y.S.2d 244 (Sup. Ct. Erie County 1969).

<sup>328</sup> See *Garone v. Roberts' Technical & Trade School, Inc.*, 47 App. Div. 2d 306, 366 N.Y.S.2d 129 (1st Dep't 1975); *Fogal v. Genesee Hosp.*, 41 App. Div. 2d 468, 344 N.Y.S.2d 552 (4th Dep't 1973). These New York cases follow the main federal case in point, *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972). A similar result has been reached in other jurisdictions. See, e.g., *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Wilkinson v. Vesey*, 110 R.I. 606, 295 A.2d 676 (1972).

In *Fogal*, the court, praising the *Canterbury* decision, stated:

In *Canterbury*, the court held that the duty and scope of disclosure arise apart from medical considerations and are not governed by the profession's standards of due care but by the general standard of conduct reasonable under all the circumstances. This general standard recognizes the patient's prerogative to decide on the projected treatment whereas a medical standard is largely self-serving.

41 App. Div. 2d at 473, 344 N.Y.S.2d at 559.

Application of the reasonableness standard has been condemned in Markham, *The Doctrine of Informed Consent — Fact or Fiction?*, 10 FORUM 1073 (1975), wherein the author, decrying the abolition of expert testimony, stated: "Such a theory totally destroys the traditional concepts that a physician is not the guarantor of a cure, and that he is liable only when he fails to conform to the standards of good practice applicable to the procedure." *Id.* at 1076 (emphasis omitted). The author, however, fails to consider why such a rule was

malpractice legislation apparently returns to the old standard requiring an expert. The Public Health Law was amended to add section 2805-d, which defines lack of informed consent as "the failure . . . to disclose to the patient such alternatives [to the treatment] . . . and the reasonably foreseeable risks . . . involved as a reasonable medical practitioner under similar circumstances would have disclosed . . ." <sup>329</sup> In addition, section 4401-a was added to the CPLR to provide that if the plaintiff brings an action based solely on lack of informed consent, a defendant's motion for judgment at the termination of the plaintiff's case is to be granted "if the plaintiff has failed to adduce expert medical testimony" to show the qualitative insufficiency of the consent. <sup>330</sup> Such a rule will create much hardship, since it is often difficult to procure an expert witness. <sup>331</sup>

The law of medical malpractice was also changed by the legislature's addition of section 4010 to the CPLR. This new provision permits the jury, or the court where it is the trier of fact, to consider collateral sources of payment when the plaintiff in an action for medical malpractice seeks recovery for rehabilitation, medical care, custodial care, or economic loss, such as loss of earnings. <sup>332</sup> As a result, the physician's insurance carrier stands to be the recipient of a windfall because of the patient's prudence in obtaining excellent insurance coverage. This is highly unsatisfac-

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formulated, *viz* to counteract the well-known reluctance of doctors to testify in malpractice actions.

<sup>329</sup> N.Y. PUB. HEALTH LAW § 2805-d(1) (McKinney Supp. 1975) (emphasis added). The theory of lack of informed consent is limited to nonemergency treatment or a diagnostic procedure involving an invasion of the body. *Id.* § 2805-d(2).

Four defenses to a malpractice action based on a lack of informed consent are included in the statute. The doctor may be able to show that "the risk not disclosed is too commonly known to warrant disclosure." *Id.* § 2805-d(4)(a). This means that it was commonly known to patients in general, not to doctors. Another defense is that "the patient assured the medical practitioner he would undergo the treatment . . . regardless of the risk involved, or . . . assured the medical practitioner that he did not want to be informed . . ." *Id.* § 2805-d(4)(b). The last two defenses are that it was not reasonably possible to obtain consent under the circumstances or that the patient was not physically or emotionally able to handle knowledge of the true risks involved. *Id.* §§ 2805-d(4)(c), (d).

<sup>330</sup> See 7B MCKINNEY'S CPLR 4401-a, commentary at 90 (Supp. 1975), which states:

If the medical activity was needful under the circumstances, the hope of this provision is that no reputable doctor will support the plaintiff's contention that he did not consent and that a disreputable doctor so testifying can be undone on cross-examination.

Whether this language permits the use of the defendant doctor as a medical expert for the plaintiff is uncertain. This was previously allowed in a malpractice action. *McDermott v. Manhattan Eye, Ear & Throat Hosp.*, 15 N.Y.2d 20, 203 N.E.2d 469, 255 N.Y.S.2d 65 (1964).

<sup>331</sup> See Comment, *Informed Consent in Medical Malpractice*, 55 CALIF. L. REV. 1396, 1405-06 (1967); 75 HARV. L. REV. 1445, 1447 (1962).

<sup>332</sup> Included under this section are any funds such as "insurance, social security . . . , workmen's compensation or employee benefit programs . . ." CPLR 4010. Excluded are collateral sources that would be entitled to reimbursement from the plaintiff's recovery. *Id.*

tory, since in effect the patient will be making payments on an insurance policy which will benefit the physician's carrier and ultimately the physician.<sup>333</sup> Since the trier of fact may give such weight to the evidence of collateral benefits as it chooses,<sup>334</sup> the jury or the court may temper this unjust result.<sup>335</sup>

The new legislation has also effected several changes in the Judiciary Law which, it is hoped, will help to clear the dockets of the current backlog of malpractice actions. To this end, the administrative board of the Judicial Conference has been given the power to promulgate rules and procedures to dispose of medical malpractice actions promptly.<sup>336</sup> Changes have also been made in

<sup>333</sup> Perhaps the recipient of such a windfall ought to reimburse the plaintiff for the premiums paid. In any event, "[i]t would seem equitable, if the defendant can adduce evidence that the plaintiff has some protection from other founts, to permit the plaintiff to show that he paid to have those founts installed." 7B MCKINNEY'S CPLR 4010, commentary at 40 (Supp. 1975).

<sup>334</sup> CPLR 4010 specifically provides that "[s]uch evidence shall be accorded such weight as the trier of the facts chooses to ascribe to it."

<sup>335</sup> See 7B MCKINNEY'S CPLR 4010, commentary at 40 (Supp. 1975). The traditional view towards collateral benefits was clearly enunciated in *Grayson v. Williams*, 256 F.2d 61 (10th Cir. 1958), where the court stated:

No reason in law, equity or good conscience can be advanced why a wrongdoer should benefit from part payment from a collateral source of damages caused by his wrongful act. If there must be a windfall certainly it is more just that the injured person shall profit therefrom, rather than the wrongdoer shall be relieved of his full responsibility for his wrongdoing.

*Id.* at 65. The court took judicial notice that personal injury cases cannot be fully compensated because of the "incidental losses and handicaps." *Id.*

Yet, others have taken the position that:

The sole purpose of a personal injury action is to compensate for actual loss. With this purpose in mind, it is difficult to comprehend how a person can be allowed to recover for a loss he never actually sustained in the name of benevolence to the most deserving.

Ghiardi, *The Collateral Source Rule: Multiple Recovery in Personal Injury Actions*, 1967 INS. L.J. 457, 460. In Hirsch, *Malpractice Crisis: Fact or Fiction*, 80 CASE & COM. July/Aug. 1975, at 3, 4, the author suggests the use of collateral sources of benefits as a means of relieving the economic burden of damage awards.

<sup>336</sup> N.Y. JUDICIARY LAW § 213(9) (McKinney Supp. 1975). The board's rules shall prescribe time limitations and procedures for the "calendaring of causes upon joinder of issue, the assignment of cases to medical malpractice panels, . . . to a trial judge or to a trial part, and the conduct of pre-trial procedures." *Id.*

Another change intended to facilitate settlement of medical malpractice claims relates to CPLR 3403(a). This section, which lists those actions entitled to trial preferences, has been expanded to include medical malpractice actions. CPLR 3403(a)(5). According to Professor David D. Siegel, the definition of medical malpractice within the new malpractice legislation, see note 283 *supra*, suggests that the preference would not include "such claims (analogous to medical malpractice if not precisely that) as those against nurses, medics, chiropractors, pharmacists, and the like." 7B MCKINNEY'S CPLR 3403, commentary at 13 (Supp. 1975).

The American Arbitration Association has offered its own solution for the speedy disposition of claims. It has established a voluntary program across New York State for the arbitration of medical malpractice actions. Under this program, the patient is asked to sign an agreement at the start of the treatment to submit any claim that may arise therefrom to arbitration. 174 N.Y.L.J. 55, Sept. 17, 1975, at 1, cols. 3-4. While such a program may facilitate claims resolution, it may be at the patient's expense. Firstly, there is no judicial review on the merits of an arbitrator's award. See *Raisler Corp. v. New York City Housing*

the procedures for cases assigned to a medical malpractice panel pursuant to section 148-a of the Judiciary Law.<sup>337</sup> The parties may now object in writing to any doctor or attorney designated for the hearing.<sup>338</sup> If the parties are unable to agree to a settlement and an action is subsequently brought, a written recommendation of the panel's finding of liability will be admissible at the request of any party, provided the panel's decision was unanimous.<sup>339</sup> The findings are not binding on the trier of fact however, and the jury or trial court may accord the recommendation any weight it may wish.<sup>340</sup> Nonetheless, it is anticipated that pretrial awareness of this right should be very effective in encouraging settlements.

Accompanying these important changes in the substantive and procedural aspects of medical malpractice law is the institution of a state board to govern the conduct of the medical profession.<sup>341</sup> Its physician members are to be appointed on recommendation by the various medical societies in the State.<sup>342</sup> Lay members are appointed by the Commissioner of Health, subject to the approval of the Governor.<sup>343</sup> The Board of Regents will have the power to

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Auth., 32 N.Y.2d 274, 282, 298 N.E.2d 91, 94-95, 344 N.Y.S.2d 917, 923 (1973); *In re Wilkins*, 169 N.Y. 494, 496-97, 62 N.E. 575, 576 (1902). Moreover, it is possible for the arbitration agreement between doctor and patient to set a ceiling on the amount recoverable which can be unrelated to the injuries sustained. *Cf. Coughlin v. MVAIC*, 45 Misc. 2d 672, 674, 257 N.Y.S.2d 549, 552 (Sup. Ct. N.Y. County 1965).

<sup>337</sup> N.Y. JUDICIARY LAW § 148-a (McKinney Supp. 1975) provides for the establishment by each department of the Appellate Division of medical malpractice panels. Each panel is to be composed of a Supreme Court Justice, a doctor, and an attorney. The doctor and attorney are chosen from those regularly practicing in the State. Only trial attorneys may be included, although their trial experience need not have been in medical malpractice cases. *Id.* § 148-a(2). All parties must be protected by the presence of counsel at the hearings. A failure to attend may result in the removal of the case from the calendar. *Id.* § 148-a(5). If a satisfactory agreement is reached, a corresponding order is to be entered. If not, the judge may schedule another hearing, or, if no solution is available, the case is to be put back on the calendar in its regular place. *Id.* § 148-a(7).

<sup>338</sup> *Id.* § 148-a(2)(d). The objection is to be decided by the presiding justice who is a member of the panel. *Id.*

<sup>339</sup> *Id.* § 148-a(8). This amendment creates an exception to the former prohibition against the admission at trial of any statement or expression of opinion made during the hearing. *Compare id. with* ch. 146, § 1(5), [1974] N.Y. Laws 843.

<sup>340</sup> N.Y. JUDICIARY LAW § 148-a(8) (McKinney Supp. 1975). If the statements are made available to the jury, the doctor or attorney members of the panel may be called as witnesses, but "with reference to the recommendation of the panel only." *Id.*

<sup>341</sup> N.Y. PUB. HEALTH LAW § 230(1) (McKinney Supp. 1975).

<sup>342</sup> *Id.*

<sup>343</sup> *Id.* The board must have at least 18 physician members, and the doctors are required to have been licensed for at least 5 years by the State. Not less than seven laymen must also be included on the board. The board's disposition is privileged from a subsequent action provided it is without malice and there was reasonable belief that it was warranted "based upon the facts disclosed." *Id.* § 230(8). To protect members at these proceedings, no right to disclosure of what transpired is available. This prohibition does not apply, however, to "statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting." *Id.* § 230(9).

The proceeding begins with a preliminary investigation either on the board's initiative

penalize doctors found guilty of professional misconduct<sup>344</sup> by the state board. Hopefully, the institution of an effective disciplinary procedure will decrease the incidence of medical malpractice.

The new act, while supposedly balancing the interests of all involved — the doctors, the insurance companies, and the general public<sup>345</sup> — does not appear to accomplish this end. It certainly has not succeeded in placating the medical profession.<sup>346</sup> The physicians object to being judged by nondoctors<sup>347</sup> and according to the standards existing at the time of the case rather than those at the time of the treatment. To avoid possible future malpractice charges, some physicians are practicing "defensive medicine" and prescribing unnecessary additional tests.<sup>348</sup> In most cases, the additional costs for these tests are borne by the patient.

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or pursuant to a complaint. *Id.* § 230(10)(a). If a hearing is warranted, charges will be lodged that state the facts material to the charges but not the evidence which will be presented to prove them. *Id.* § 230(10)(b). A hearing will be held not more than 35 days after the charges are filed. *Id.* § 230(10)(c). To protect the doctor, the hearing will be conducted by a board other than the one that filed the charges. *Id.* § 230(10)(e). If the second board sustains the charges at the hearing, the commissioner will receive a copy and may make a recommendation to the Board of Regents, which has the final decision as to the doctor's professional misconduct. *Id.* §§ 230(10)(g), (h), (i). For a definition of professional misconduct see note 344 *infra*.

<sup>344</sup> Professional misconduct includes such practices as: (1) fraudulently obtaining a license; (2) practicing the profession with gross negligence on one occasion or "negligence or incompetence on more than one occasion"; (3) practicing while ability is impaired by alcohol, drugs, or a physical or mental disability; (4) being habitually drunk or a drug user; (5) being convicted of a crime under state or federal law; (6) refusing service on prejudicial grounds; (7) aiding in the unauthorized practice of medicine; (8) practicing with a suspended license or failing to notify the department of change of name or address; (9) committing unprofessional conduct. N.Y. EDUC. LAW § 6509 (McKinney Supp. 1975).

A new section was added to the Education Law which governs the Board of Regents' handling of proceedings involving medical malpractice. *Id.* § 6510-a. Section 6511 provides for such penalties as "censure and reprimand," suspension, revocation or annulment of the license, and limitation on any later registration or license. Under the new amendment, the suspension can be complete for a fixed period or either partial or complete pending successful completion of a retraining course. *Id.* § 6511.

<sup>345</sup> See Governor's Memorandum, May 21, 1975, as appearing in [1975] N.Y. Laws 1739 (McKinney), on approving ch. 109, §§ 1-37, [1975] N.Y. Laws 134 (McKinney).

<sup>346</sup> See N.Y. Times, May 29, 1975, at 22, cols. 7-8; note 290 and accompanying text *supra*.

<sup>347</sup> N.Y. Times, June 1, 1975, § 1 (News), at 46, col. 5, quoting Stephen H. Mackauf, Esq., member of the Committee on Medicine and Law of the Association of the Bar of the City of New York:

"The doctors have an ego problem when it comes to lawsuits which are critical of them," he said. "While the doctors can be very critical of themselves in their own conferences, when a layman says they've done something wrong they can't cope with it."

That such lawsuits are either embarrassing or expensive to the doctors should not lead to their immunity therefrom, however, since such a privileged status is "enjoyed by no other persons and . . . runs counter to the entire development of tort law in the present century." Special Advisory Panel on Medical Malpractice, *Memorandum of Position of N.Y. St. Ass'n Comm. on Tort Reparations*, 48 N.Y. ST. B.J. 26, 27 (1976).

<sup>348</sup> N.Y. Times, July 27, 1975, at 30, col. 1; *id.*, June 5, 1975, at 28, col. 5; *id.*, June 1, 1975, § 1 (News), at 46, col. 4.

Another objection of the medical profession is to the contingency fee system. Doctors contend that it influences lawyers to push for higher jury awards.<sup>349</sup> Yet, of the 2000 malpractice claims finalized in 1974, no awards were made in 70 percent of the cases.<sup>350</sup> Assuming most claims are taken on a contingency fee basis, this would seem to indicate that most lawyers were paid nothing for their services.

Dealing with the medical malpractice crisis was obviously a trying task for the legislature. The problems of medical malpractice insurance are manifold since they touch upon "issues of vital concern to the medical and legal professions, the insurance industry and consumers."<sup>351</sup> When threats were made to end malpractice insurance unless rates were precipitously raised, the legislature quickly responded out of concern for the continued availability of malpractice insurance in New York. Nevertheless, close analysis of the legislation suggests that the legislature may have acted too hastily.<sup>352</sup> Perhaps, rather than submitting to claims that malpractice insurance was unprofitable and the rates must be increased, the legislature should have investigated the claims more fully before changing the law.<sup>353</sup> In any event, the real party who must ultimately bear the weight of increased premiums is the public.<sup>354</sup>

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<sup>349</sup> *Id.*, June 6, 1975, at 18, col. 2. On the other hand, it has been argued that since lawyers discourage the bringing of claims which are not both substantial and meritorious, they, together with the legal system in general, "actually insulate the medical profession from a large percentage of the potential claims against it." Special Advisory Panel on Medical Malpractice, *Memorandum of Position of N.Y. St. Ass'n Comm. on Tort Reparations*, 48 N.Y. St. B.J. 26, 27 (1976).

<sup>350</sup> N.Y. Times, June 1, 1975, § 1 (News), at 46, col. 4.

<sup>351</sup> Governor's Memorandum, May 21, 1975, as appearing in [1975] N.Y. Laws 1739, 1740 (McKinney), on approving ch. 109, § 1-37, [1975] N.Y. Laws 134 (McKinney).

<sup>352</sup> Dean McLaughlin has commented:

The primary purpose of the new malpractice bill is to minimize claim loss experience so that medical malpractice insurance premiums will be kept within acceptable reach. To accomplish this objective many rational considerations fell by the wayside as a politically expedient solution acceptable to everyone caught up in the malpractice maelstrom evolved.

7B MCKINNEY'S CPLR 214-a, commentary at 48 (Supp. 1975). He has described the final form of the legislation as "a melange of substantive and procedural provisions that are not entirely coherent." *Id.* 208, commentary at 26.

<sup>353</sup> Unfortunately, the State Insurance Department has never fully assessed whether the private companies have profited from the writing of medical malpractice insurance. N.Y. Times, June 1, 1975, § 1 (News), at 46, col. 6. Apparently, part of the problem has been the lack of information on these private companies. *Id.*, May 29, 1975, at 22, col. 5. It would appear that the legislature has decided to attack this problem after precluding the claims of many plaintiffs, rather than before. The new legislation requires insurance companies issuing malpractice insurance policies to file detailed claim reports with the Superintendent of Insurance and the Commissioner of Health as to "all claims for medical malpractice made against any of its insureds and received by it during the . . . six month period" prior to the issuance of such insurance. N.Y. INS. LAW § 335(1) (McKinney Supp. 1975).

<sup>354</sup> N.Y. Times, July 27, 1975, at 1, col. 4.

Since the public is in effect the insurer, it is submitted that consideration should be given to State assumption of this function.<sup>355</sup>

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<sup>355</sup> The solution of the problem is not no-fault insurance, according to one author. Keeton, *Compensation for Medical Accidents*, 121 U. PA. L. REV. 590, 597-98 (1973). The primary reason for this view is that medical malpractice actions raise difficult questions of causation. *Id.* at 597. For a discussion of the complex causation problems that arise in the area of medical malpractice, see D. LOUISELL & H. WILLIAMS, 1 MEDICAL MALPRACTICE § 8.07 (1973).